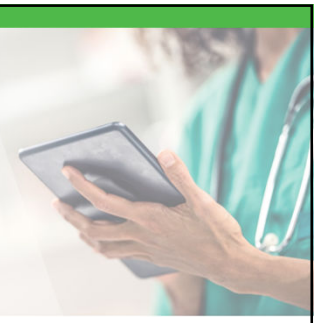
Mitigating Professional Liability Claims in Neurosurgery



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Disclaimer

The information provided in this presentation offers risk management strategies and resources, and the slide content is intended to be used only with the accompanying oral presentation.

Guidance and recommendations contained in this presentation are not intended to determine the standard of care but are provided as risk management advice only. The ultimate judgment regarding the propriety of any method of care must be made by the healthcare professional.

The information does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about this topic should be directed to an attorney.

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Faculty *The presenter and planners of this activity have no relevant financial relationships to disclose.*

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Learning Objectives

This educational activity will support your ability to:

- Understand closed claim trends in neurosurgery
- Improve your informed consent process
- Develop a proactive approach to disclosing unanticipated events or outcomes
- Apply communication and documentation best practices to prevent and aid in defensibility of claims

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Neurosurgery Closed Claim Trends

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Claims Summary: Neurosurgery vs. All Specialties

	Closed Claims	Paid Claims	PTC Ratio	Average Indemnity	Total Indemnity
Neurosurgery	514	136	26.5%	$542,480	$74 Million
All Specialties	32019	8818	27.5%	$356,572	$3.1 Billion

Source: Data Sharing Project Dashboard (2010-2021). MPL closed claims. MPL Association. Retrieved by ProAssurance (Apr 23, 2024).

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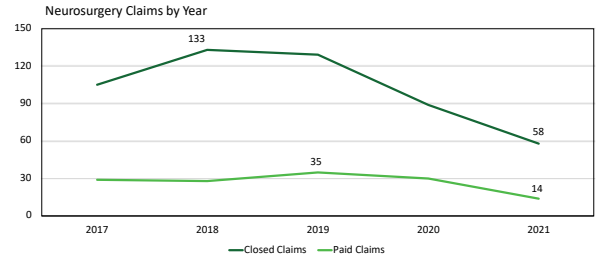
MPL Neurosurgery Closed Claim Volume



Source: Data Sharing Project Dashboard (2010-2021). MPL closed claims. MPL Association. Retrieved by ProAssurance (Apr 23, 2024).

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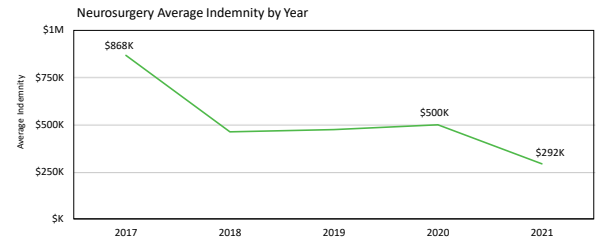
Neurosurgery Claim Severity



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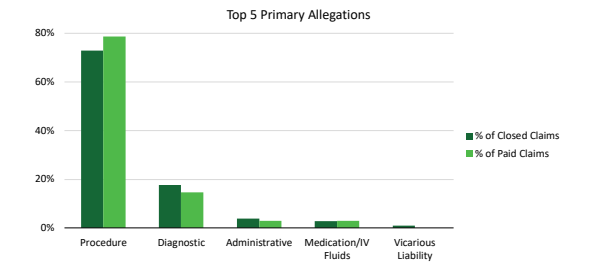
Most Common Allegations in Neurosurgery Claims



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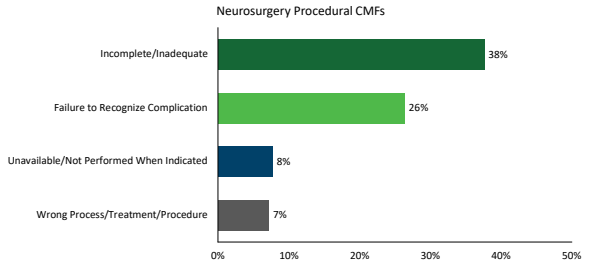
Chief Medical Factors Associated with Procedural Allegations



Source: Data Sharing Project Dashboard (2010-2021). MPL closed claims. MPL Association. Retrieved by ProAssurance (Apr 23, 2024).

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Most Common Procedures in Neurosurgery Claims

Top Procedures	Closed Claims	% of Closed Claims
Spinal fusion	139	27.0%
Other diagnostic procedures	56	10.9%
Laminectomy; excision intervertebral disc	50	9.7%
Other OR therapeutic nervous system procedures	42	8.2%
Destruction, resection, or excision of intervertebral disc	26	5.1%
Total	**313**	**60.9%**

Source: Data Sharing Project Dashboard (2010-2021). MPL closed claims. MPL Association. Retrieved by ProAssurance (Apr 23, 2024).

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Most Common Outcomes in Neurosurgery Claims

Top Outcomes	Closed Claims	% of Closed Claims
Intraoperative and postprocedural complications and disorders of nervous system, not elsewhere classified	41	8.0%
Complications of procedures, not elsewhere classified	40	7.8%
Paraplegia (paraparesis) and quadriplegia (quadriparesis)	40	7.8%
Complications of internal orthopedic prosthetic devices, implants, and grafts	22	4.3%
Other paralytic syndromes	20	3.9%
Total	**163**	**31.7%**

Source: Data Sharing Project Dashboard (2010-2021). MPL closed claims. MPL Association. Retrieved by ProAssurance (Apr 23, 2024).

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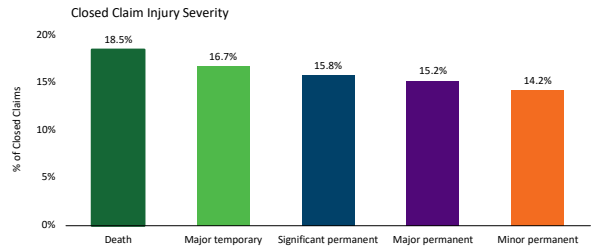
Most Common Severity of Injury in Neurosurgery Claims



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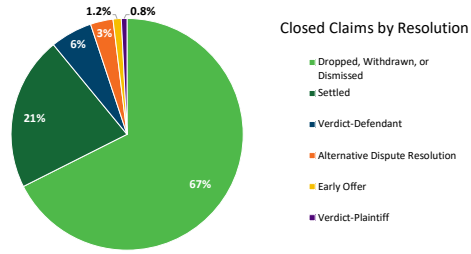
Neurosurgery Claims Resolution Distribution



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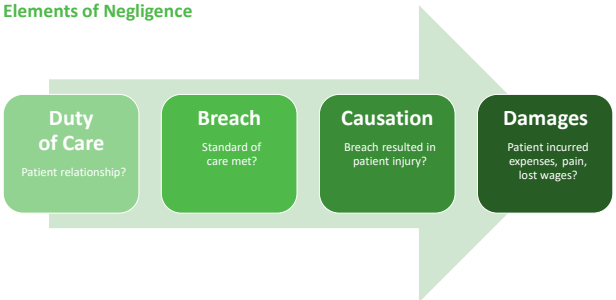
Elements of Negligence



(Pozgar 2019, 44)

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Standard of Care

- The yardstick by which the defendant-physician's conduct is measured
- Established in court by the testimony of expert witnesses
- What would a similarly situated physician have done?
- "Battle of experts" who testify on behalf of either the plaintiff-patient or defendant-physician about whether or not the physician's conduct met that standard of care, considering the factors at play when the treatment was delivered
- We often use expert reviewers' opinions at the beginning of a suit to gauge our insured's position and determine defensibility.

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Closed Claim Case Examples

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Case Study #1

A 41-year-old male with multiple comorbidities presented to ED after falling out of bed and hitting his head on a side table two days earlier; CC = Headache.

A CT scan revealed a brain bleed. Patient was transferred to nearby trauma hospital and was evaluated by the on-call trauma surgeon.

Trauma surgeon determined the patient was stable, but CT was concerning for injury to the brain with a few areas of bleeding.

Trauma surgeon consulted neurosurgeon after ordering a repeat CT scan and admitting the patient to SICU.

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Case Study #1

Neurosurgeon (insured) evaluated the patient and felt the area of bleeding was unusual for traumatic bleeding given the location, aneurysm, and potential bleeding tumor included in differential. CTA was ordered but negative.

Plan = monitor the patient's progress over the next 24-48 hrs; consider ventricular drain placement.

Patient experienced seizures during this period. His condition deteriorated to the point of him ultimately requiring intubation.

Patient passed away four days after the neurosurgeon's initial consultation.

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Legal Factors

- Patient's wife filed suit against neurosurgeon alleging failure to perform a craniotomy to evacuate the intracranial hematoma, as well as place a ventricular drain, resulted in husband's death
- Defense expert: Supportive of neurosurgeon's care and decision that surgery was not initially warranted, but felt the neurosurgeon's postmortem note stating bleed likely due to aneurysm will negatively impact credibility
- Plaintiff expert: opined surgery was indicated sooner, while drain placement difficult should have been attempted and if not possible, should have placed pressure monitor

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Case Discussion

- Credibility issues related to documentation postmortem suspecting aneurysm as cause of death
- Neurosurgeon never spoke with patient's family during admission; family not involved in decisions re: surgical intervention
- Wife asked to meet/speak with neurosurgeon on the day he began having seizures, and the neurosurgeon did not meet with her until after his death
- The pathologist who did the autopsy stated the cause of death was hemorrhage due to fall

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Risk Management Considerations

Communication breakdowns are common themes observed in closed claim cases

- Improve communication to reduce medical errors and improve trust
- Acknowledge that the diagnostic process inherently involves uncertainty and share this with patients

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Risk Management Considerations

- Involve patients and their families in the shared decision-making process when there are risks associated with both taking action and watchful waiting
- Approach and document these discussions similarly to informed consent discussions where risks, benefits, and alternatives are reviewed, and patients are given the opportunity to ask questions
- If watchful waiting is planned, communicate to the patient, family, and medical support staff what, when, and how to alert you of alarm symptoms requiring intervention, thus creating a "diagnostic safety net"

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Case Study #2

A 45-year-old female with multilevel cervical pathology presents for C5/6 arthroplasty after failed conservative therapy.

Notably, the patient initially presented for surgery a week earlier, but surgery was aborted after induction of anesthesia as the fluoroscopy machine was not working properly.

Patient had congenital auto-fusion of C2 and C3, and intra-op fluoroscopy was used to identify the C5/6 level.

After positioning the implant at the operative level, the surgeon's attention was brought to the level above.

He noted significant degeneration and large osteophytes at this level.

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Case Study #2

He reassessed the pre-op imaging, and multiple images were obtained under fluoroscopy which ultimately revealed he operated at C6/7.

He paused surgery to discuss the scenario further with the patient's husband, and the husband recalls the surgeon asking for permission to do an additional level since it was noted to be diseased intraoperatively.

As the patient and her husband were leaving the surgical center, they were handed copies of the films and reportedly told, "Here, you are going to need these."

Post-op records reviewed by the family revealed that the C6/7 level was operated on first followed by the C5/6 level.

The patient has continued neck pain with moderate canal narrowing at C4/5, with a midline central disc herniation and mild cord impingement.

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Legal Factors

- The patient filed a lawsuit against the neurosurgeon alleging that negligent cervical arthroplasty resulted in surgery at the wrong level
- Defense experts: Multiple experts could not support the standard of care given the wrong-level surgery, but most agreed that the patient was likely not currently suffering from damages as a result of the additional-level surgery
- Plaintiff expert: Critical of the placement of artificial disc at C6/7, opined that the patient's current neck pain is from the surgery, and opined the patient will need a cervical spine fusion in the future
- Claim for punitive damages based upon allegation that the neurosurgeon purposefully misrepresented what had happened in the first part of the surgery, while obtaining additional consent to hide that he had operated on the wrong level

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Case Discussion

- A motion to dismiss/strike the punitive damages from the case was denied by the judge given the wrong-level surgery
- The physician's recollection of his conversation with the patient's husband varies greatly from the patient's and would be left up to the jury to decide who to believe
- The physician's recollection of discussing the additional risk of a wrong-level surgery due to the patient's anatomy was not documented, and the patient does not remember this being discussed
- Ultimately it was decided to settle the case to avoid the risk of an excess verdict given the pursuit of punitive damages and a clear surgical error

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Risk Management Considerations – Informed Consent

- A process, not a form:
  - Discussion - diagnosis, treatment, alternatives, prognosis/risks/benefits
  - Decision - patient's ability to make decision should be assessed
  - Documentation - of discussion elements, the patient's opportunity to ask questions, understanding of information, and desire to proceed
- Remember to discuss additional risks unique to the patient's clinical picture.
- Goal: Review risks, benefits, alternatives, AND set proper expectations.

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Risk Management Considerations – Wrong-Site Surgery Prevention

- Be particularly aware of wrong-site surgery risks in patients with anatomical variations such as cervical ribs, lumbar ribs, or transitional anatomy
- Consider incorporating key elements from TJC's Universal Protocol into your pre-operative process:
  - Conduct a pre-procedure verification process in which you verify the correct surgery is done on the correct patient, and at the correct place on the patient's body
  - Mark the correct procedure site before the procedure is performed
  - Perform a time-out in which you pause before the surgery to make sure that a mistake is not being made.
- Foster a culture of safety where team members feel empowered to speak up if they notice discrepancies during any step leading up to the procedure

The Joint Commission, The Universal Protocol Poster

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Disclosure

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Physician-Patient Communication

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Disclosure Risk Reduction Strategies

- Know disclosure process
- Work with Risk Management
- Prepare for disclosure conversation
- Be open, honest, and respectful
- Choose words carefully

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Disclosure Discussion Documentation—Dos

- What to document in the medical record:
  - The date, time, and location of the discussion
  - All parties and relationships of those present
  - All questions asked and answered
  - Your commitment to share additional information as it becomes available and to assist the patient and family.

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Disclosure Discussion Documentation—Don'ts

- What not to document:
  - Admissions of liability or statements of blame
  - References to the cause of the outcome without the clinical facts to back it up
  - References to any future peer review proceedings
  - Legal aspect or conversation in the medical record

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Additional Resources

- ProAssurance Risk Management Website
  - Education, Publications, Seminars
- Informed Consent Seminar
- Medical Error: Reducing Liability Risk by Changing the Narrative Seminar
  - Part One: Dr. Danielle Ofri
  - Part Two: Billy Bates, Esq.

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Closing Thoughts

1. Most physicians will eventually encounter an unanticipated result
2. First, take care of the patient
3. You have the ability to influence a patient's successful pursuit of a claim - response and documentation are crucial
4. Taking time to build rapport and trust through patient interactions builds trust instead of blame
5. Kindness wins

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THANK YOU

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References

- "Data Sharing Project Dashboard (2010-2021), Medical Professional Liability (MPL) closed claims," MPL Association, retrieved by ProAssurance Apr 23, 2024.
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